

# California Medi-Cal 2020 Demonstration

## Access Assessment Design

DRAFT



## Table of Contents

<b>1. Background</b>	<b>1</b>
Overview of California’s Section 1115(a) Medicaid Waiver Renewal	1
Key Components of Access Assessment	2
Access Assessment Objectives	3
<b>2. Assessment Framework</b>	<b>4</b>
Scope of the Access Assessment	4
Assessment Framework	5
Intersecting Dimensions of Access	7
<b>3. Assessment Design</b>	<b>8</b>
Study Population	8
Data Collection and Sources	10
<hr/>	
Public Comment	27
Access Assessment Deliverables Timeline	27
<b>Appendix A. Medi-Cal Managed Care Health Plan Reporting Unit and Urbanicity</b>	<b>A-1</b>

## Overview of California's Section 1115(a) Medicaid Waiver Renewal

On December 30, 2015, California's Section 1115(a) Medicaid Waiver Renewal, entitled *California Medi-Cal 2020 Demonstration (Medi-Cal 2020)*,<sup>1</sup> was approved by the Centers for Medicare & Medicaid Services (CMS). *Medi-Cal 2020* continues the State's commitment to improving California's health care delivery system and builds upon the successes of the previous 2010 Section 1115(a) *Bridge to Reform* waiver. Critical to the ongoing success and viability of Medi-Cal Managed Care (MCMC), the *Medi-Cal 2020* waiver serves to guide the California Department of Health Care Services (DHCS) through the next five years as DHCS works to transform the quality of care, access to care, and the efficiency of health care services for MCMC beneficiaries.

recommendations in response to any systemic network adequacy issues identified.

Following approval on July 25, 2016 (Senate Bill 815), DHCS amended its contract with Health Services Advisory Group, Inc. (HSAG), the current External Quality Review Organization (EQRO), to design and conduct the required Access assessment. Effective October 23, 2016, HSAG began working with DHCS to develop the overall Access assessment design, including facilitation of an advisory committee formed to provide input on the assessment structure. As required by the STCs, the following design outlines the proposed methods for addressing the STCs and assessing MCMC beneficiaries' access to health care services. Subject to CMS approval, the design will guide the data collection, calculation of access-related measures, and reporting of MCP and State compliance with existing network adequacy and timely access requirements.

---

<sup>1</sup> Medi-Cal 2020 Demonstration Approval. (2015, December 30). Retrieved March 11, 2017, from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/medi-cal-2020/ca-medi-cal-2020-demo-appvl-12816.pdf>.

<sup>2</sup> California Medi-Cal 2020 Demonstration, Special Terms and Conditions. (2017, January 19). Retrieved March 11, 2017, from <http://www.dhcs.ca.gov/provgovpart/Documents/MediCal2020STCTCjan192017.pdf>.

<sup>3</sup> Network standards assessed in this Access assessment are based on requirements outlined in the Knox-Keene Health Plan Service Act of 1975 (KKA) and current MCMC contracts.

## Key Components of Access Assessment

The requirements for the *Medi-Cal 2020* Access assessment include the following key components:

- ◆ **Establishment of the Access Assessment Advisory Committee (AAAC)**—Based on submitted applications, DHCS selected 18 committee members in 2016 to participate on an advisory committee tasked with providing feedback on the overall assessment design and the final report. The AAAC members were selected from a variety of backgrounds including consumer advocacy organizations, providers/provider associations, health plans/health plan associations, legislative staff, and MCMC beneficiaries. The mix of committee members ensures diverse and robust input on the development of the assessment methodology.

Facilitated by HSAG, the AAAC members have met on three separate occasions

- ◆ **Preparation and Submission of an Access Assessment Design to CMS**—Working collaboratively with DHCS and the AAAC, HSAG will develop a detailed assessment design for submission, review, and approval by CMS. The Access assessment design will highlight the data sources, access measures, and assessment methods identified to support the review of the adequacy of Medi-Cal’s beneficiaries’ access to services. Upon approval from CMS, HSAG and DHCS will have ten months to execute the Access assessment design.
- ◆ **Preparation and Submission of Initial Draft and Final Access Assessment Reports**—Once the Access assessment results are compiled, HSAG will review the assessment findings with the AAAC and DHCS. HSAG will then produce an initial draft report and submit the report to the AAAC and DHCS. Upon receiving feedback, HSAG will modify the draft report as needed. DHCS will then publish the draft report for public comment, and include documentation of the AAAC’s feedback. Following closure of the public comment period, HSAG will prepare a final report for submission to DHCS and CMS.

---

<sup>4</sup> The AAAC was convened on November 18, 2016, January 31, 2017, and March 28, 2017; meetings were open to the public.

## Access Assessment Objectives

Based on the requirements outlined in the STCs and the goals of *Medi-Cal 2020*, the Access assessment will address the following objectives:

1. Assess MCP network adequacy and performance for managed care beneficiaries.
2. Assess MCP network compliance with established network standards and timely access requirements.<sup>5</sup>
3. Assess compliance with network adequacy requirements across MCPs and lines of business
4. Identify differences between the State's current network monitoring program and the requirements outlined in the Medicaid and Children's Health Insurance Program (CHIP) managed care final rule (42 Code of Federal Regulations [CFR] 438).

The Access assessment design, taking into account the four objectives outlined preceding, uses the access performance measures and analytic approach to address multiple dimensions of access (i.e., network capacity, geographic distribution, and availability of services), as described in Section 2—Assessment Framework.

---

<sup>5</sup> Network standards reported in this Access assessment are based on requirements outlined in the Knox-Keene Health Plan Service Act of 1975 (KKA) and MCMC contracts.

## Scope of the Access Assessment

The scope of work of this Access assessment includes an investigation of MCP network adequacy for managed care beneficiaries covered by the Knox-Keene Health Plan Service Act of 1975 (KKA) and existing Medi-Cal managed care contracts. As a one-time study, the Access assessment will provide a broad, cross-sectional profile of both Medi-Cal and MCP provider networks as well as a comparison of network performance relative to established network standards<sup>6</sup> and outcomes. Specifically, the Access assessment will:

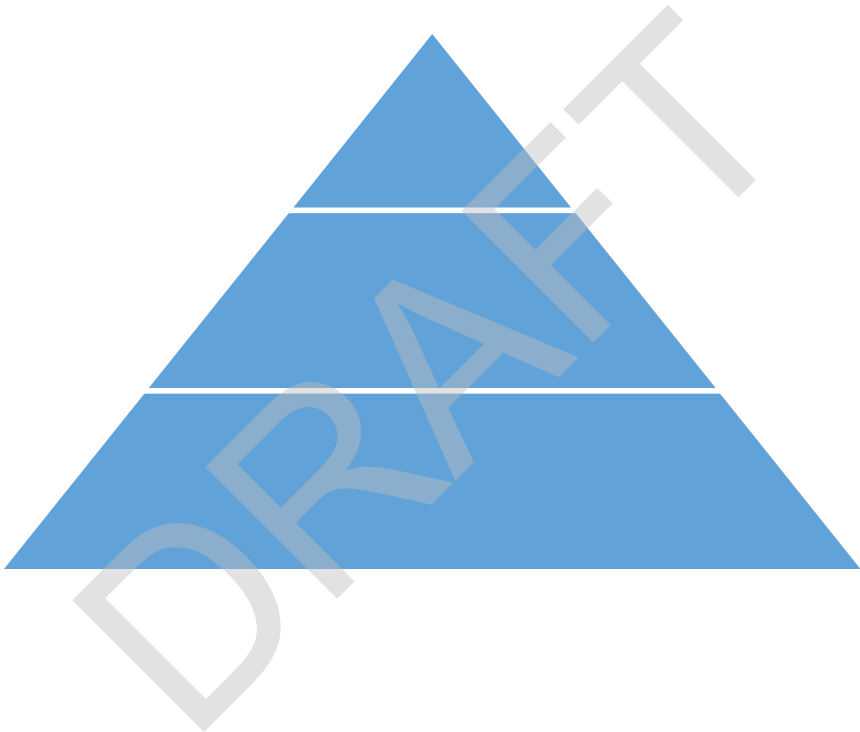
- ◆ Measure MCP compliance with existing network adequacy and with timely access requirements set
- ◆ Account for geographic differences (i.e., urban versus rural), previously approved alternative access standards (as applicable), and network status (i.e., in- or out-of-network).
- ◆ Present network adequacy and timely access findings at the State contractor MCP level as well as key beneficiary, provider, and geographic subpopulations as noted previously.

Focusing on the Medi-Cal-only managed care population, the Access assessment will be limited to evaluation of California's managed care service areas. Additionally, while HSAG will use some beneficiary demographics to assess network adequacy, HSAG will not disaggregate results by clinical or program-based subpopulations (e.g., disabled beneficiaries, foster care children).

---

<sup>6</sup> Network standards assessed in this Access assessment are based on requirements outlined in the Knox-Keene Health Plan Service Act of 1975 (KKA) and MCMC contracts.

<sup>7</sup> Please note that while CMS has finalized the Medicaid Managed Care rule (42 CFR 438), the current Access assessment is limited to evaluation of existing standards in MCMC. As such, new network requirements will not be directly incorporated into this assessment.



- ◆ Is the geographic distribution of providers relative to the beneficiary population reasonable?
- ◆ Does the geographic distribution of providers mirror the social, cultural, and clinical needs of the beneficiary population?

Key measures for assessing the geographic distribution of providers include time/distance analyses and compliance with network adequacy requirements. When combined with beneficiary and provider characteristics, these analyses will determine the extent to which the supply of providers is distributed appropriately relative to the beneficiary population. However, even with adequate capacity and appropriate distribution of services, assessing the *availability* of relevant services is critical in making sure beneficiaries have access. The third dimension of access, *Availability of Services*, is important for understanding the extent to which network services are relevant and effective in producing positive health outcomes. Key questions addressed by this dimension include the following:

DRAFT

### Geographic Distribution

- Time/distance analysis
- Network adequacy

### Availability of Services

- Use of services
- Appointment availability
- Grievances and appeals/complaints



## Intersecting Dimensions of Access

Taken individually, the dimensions of access described in Figure 2.2 are incomplete. Instead, evaluation of network adequacy should encompass all three dimensions in order to understand the impact of both network infrastructure and the implementation and actions of that infrastructure. While individual dimension results are important, the interaction of provider capacity and geographic distribution, along with appointment availability, provide a comprehensive picture of the adequacy of the Medi-Cal managed care provider networks.

To ensure that Medi-Cal beneficiaries have the potential to access the health care services that they need, HSAG will assess the existing capacity of MCPs' provider networks and those networks' abilities to afford access to health care services (i.e., *Network Capacity*). This component is key to establishing adequate access, although it is insufficient on its own to support the access and availability expectations of MCMC beneficiaries. Insufficient providers and the lack of specialists in a network have a direct impact on beneficiaries' access to care. HSAG will also examine the extent to which the distribution of Medi-Cal enrolled providers' practice locations mirror those of the beneficiary populations they serve (i.e., *Geographic Distribution*). Even with a large network of enrolled providers, if the providers are not distributed appropriately and proportionally relative to the beneficiaries, access to care will be adversely affected. Beneficiaries' access to local care is critical to ensuring that beneficiaries receive the health care services they need.

In addition to understanding the underlying provider network infrastructure, HSAG will also assess how well the network addresses the needs (clinical and cultural) of the beneficiaries (i.e., *Availability of Services*). For example, while a sufficient number of providers may be enrolled in a network and distributed proportionally relative to the enrolled beneficiary population, the providers must be active and willing to accept Medi-Cal patients. While individual dimension results are important, the interaction of provider capacity and geographic distribution, along with availability of services, is critical to developing a comprehensive picture of the adequacy of California's Medi-Cal managed care network provider networks.

### 3. Assessment Design

The primary objective of the Access assessment is to explore and assess Medi-Cal managed care beneficiaries' access to primary, core specialty, and facility services. As outlined in Section 2, HSAG will employ a multi-dimensional analytic approach to investigate existing levels of access as well as compliance with the managed care network adequacy requirements set forth in the KKA and current MCMC contracts. HSAG will assess access to care using a combination of network performance measures including descriptive statistics, point-in-time estimates and trend analyses, and utilization metrics. Synthesizing the results across each measure will provide a comprehensive profile of the capacity, distribution, and availability of health care services available to MCMC beneficiaries.

Although HSAG will present results at the statewide and managed care contractor levels, the Access assessment will include a series of comparative analyses that target the impact of key beneficiary, provider, and geographic (i.e., urban versus rural) characteristics on MCMC beneficiaries' access to care. These subgroup comparisons will allow DHCS to understand how access to services is affected by both geographic setting and beneficiaries' characteristics, as well as by differences in managed care provider networks. The following section outlines the population, data sources, and analytic methods that HSAG will use to conduct the Access assessment.

of beneficiary enrollment data.

**Table 3.1—Provider Categories Included in the Access Assessment**

Provider Category	Provider Specialty/Type <sup>A</sup>
Primary Care Physician	<ul style="list-style-type: none"> <li>◆ Family Practice</li> <li>◆ General Practice</li> <li>◆ Geriatrics</li> <li>◆ Internal Medicine</li> <li>◆ Obstetrics/Gynecology<sup>B</sup></li> <li>◆ Pediatrics</li> <li>◆ Preventive</li> </ul>
Non-Physician Medical Practitioner <sup>8</sup>	<ul style="list-style-type: none"> <li>◆ Physician Assistant</li> <li>◆ Nurse Practitioner</li> <li>◆ Certified Nurse Midwife<sup>B</sup></li> </ul>
Core Specialty Care	<ul style="list-style-type: none"> <li>◆ Cardiovascular Disease/Interventional Cardiology</li> <li>◆ Nephrology</li> <li>◆ Neurology</li> <li>◆ Obstetrics/Gynecology<sup>B</sup></li> <li>◆ Ophthalmology</li> <li>◆ Ophthalmology, Otolaryngology, Rhinology (ENT)</li> <li>◆ Orthopedic Surgery</li> <li>◆ Pediatric Mental Health Specialists</li> <li>◆ Pediatric Physical Health Specialists</li> <li>◆ Physical Medicine and Rehabilitation</li> <li>◆ Mental Health Outpatient Services<sup>C</sup></li> <li>◆ Psychiatry</li> <li>◆ Pulmonary Disease</li> </ul>
Facility-based and Special Providers	<ul style="list-style-type: none"> <li>◆ Community Based Adult Services (CBAS)</li> <li>◆ Federally Qualified Health Center (FQHC)</li> <li>◆ Home Health</li> <li>◆ Hospital, Inpatient</li> <li>◆ Hospital, Outpatient</li> <li>◆ Intermediate Care Facility (ICF)</li> <li>◆ Rural Health Clinics (RHC)</li> <li>◆ Skilled Nursing Facility (SNF)</li> </ul>

<sup>A</sup> Provider specialties are subject to change based on the final network adequacy standards defined by DHCS.

<sup>B</sup> Obstetricians/Gynecologists and Certified Nurse Midwives will be evaluated both within the primary care physician category, when identified as primary care physician, and independently.

<sup>C</sup> This category will include providers who deliver mental health services in outpatient settings including, but not limited to, licensed clinical social workers; marriage, family, and child counselors; substance use counselors; Qualified Autism Services Practitioners (QASPs); paraprofessional behavior technicians; and psychologists.

<sup>8</sup> Except in instances where non-physician practitioners are being evaluated for compliance with existing network standards, categorization of non-physician medical practitioners will be based on defined specialties. To eliminate inflation of network performance measures, HSAG will exclude non-physician medical practitioners with no designated specialty.

DRAFT

(274). All MCPs are expected to be in production by May 2017 and to include monthly provider data from January 1, 2017, through the present. After MCPs have fully implemented 274 reporting, DHCS will validate and make the data available to HSAG for analysis.

Note that due to the frequency of changes in provider practices (e.g., acceptance of new patients, network status, and office location), provider data are accurate as of the time of submission. Additionally, certain fields related to practice characteristics may be incomplete or require additional reconciliation due to differences in the data collection and classification processes at individual MCPs.

Provider data will be extracted from the DHCS data warehouse for the following time period: January 1, 2017, through September 30, 2017.

### Data Warehouse—Encounter Data

DRAFT

Although each data source becomes available on a differing schedule (e.g., monthly, quarterly), data from each source will be collected for the following time period: October 1, 2016, through September 30, 2017—with rates being reported monthly.

## HEDIS IDSS and PLD Files

The Interactive Data Submission System (IDSS) data contains Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>)<sup>9</sup> data collected and reported by the Medi-Cal MCPs. This audited information is used to report each MCP's results for Medi-Cal's External Accountability Set (EAS), a set of performance measures selected annually by DHCS to monitor MCP performance. HSAG will use a subset of measures from this data source to report key HEDIS measures highlighting beneficiaries' access to care. Additionally, all MCPs are required to submit both NCQA-required Patient-Level Detail (PLD) files and CA-specific PLD files as part of the HEDIS audit process. The PLD files contain beneficiary-level results.

HEDIS IDSS and PLD files will be available in June 2017 for measurement period 2016. HEDIS measures reported in the Access assessment will cover dates of service during the following time period: November 6, 2015, through December 31, 2017.

Survey-based data represent information collected directly from beneficiaries and providers and reflect patient and provider experiences. As noted in the STCs, HSAG will use data collected through DHCS's Audits & Investigations Division (A&I) to assess appointment availability and compliance with timely access standards outlined in the KKA and MCP contracts. Data collected through these surveys will identify appointment wait times associated with the first, second, and third available appointments. To assess timely access, the Access assessment will incorporate results from the audit, verification, and post-audit studies conducted by DHCS. Depending on the volume and quality of data collected, HSAG may produce descriptive statistics and conduct comparative analyses across key characteristics.

Survey data related to timely access will be procured for the following time period: January 1, 2017, through September 30, 2017.

---

<sup>9</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).



Quest Analytics software. During the geo-coding process, HSAG analysts will highlight and correct those addresses which include inaccurate zip codes, where possible, to maximize the number of providers and beneficiaries included in the assessment. HSAG will limit the final MCMC beneficiary population included in the Access assessment to beneficiaries residing within the State of California; however, HSAG will include all providers contracted by Medi-Cal MCPs in the assessment, regardless of office location.<sup>10</sup> Key activities of the preliminary file review will be confirming and evaluating the categorization of selected specialties and providers to ensure consistency across MCPs. HSAG will exclude from the analysis providers with no specialty identified or with a specialty not matching the listed categories within the provider crosswalk.

At a minimum, following the preliminary review HSAG will produce both demographic profiles and population counts by key stratification variables including the following:

- ◆ Beneficiary population counts by MCP, gender, age, race/ethnicity, and geography

As noted earlier, HSAG will evaluate three dimensions of provider access and timely access (i.e., network capacity, geographic distribution, and availability of services). Together, results from these three dimensions provide insight into the underlying network infrastructure as well its application and interaction with MCMC beneficiaries.

### **Network Capacity**

Network Capacity addresses the underlying infrastructure of a provider network. Measures of network capacity assess whether or not health services are available to beneficiaries through a sufficient supply and variety of providers. Following are descriptions of the three measures that HSAG will use to assess the network capacity of MCMC provider networks.

---

<sup>10</sup> HSAG will individually evaluate outlier provider locations to ensure that no skewing or bias of provider-to-enrollee ratio or time/distance results occurs.

<sup>11</sup> *Level of activity* will be evaluated by linking provider network data to encounters and identifying the volume of services rendered by a given provider. This analysis assists in defining the difference between being listed in an MCP's provider network and rendering services. Differences noted in the analysis may indicate a gap in the provider network.



## Beneficiary Count and Provider Supply

HSAG will calculate frequency distributions of both beneficiaries and physicians to provide a demographic profile of the MCMC beneficiary population and provider networks. In addition to presenting results by MCP and statewide, HSAG will stratify the provider network counts by physician specialty and category to allow comparative analyses across key characteristics (e.g., MCP and physician). HSAG will highlight in the results, by strata, differences in the classification and/or count of beneficiaries and providers. Table 3.3 describes key specifications for this measure.

**Table 3.3—Measure Specifications: Beneficiary and Provider Counts**

Measure Element	Description
	<ul style="list-style-type: none"> <li>◆ The number of unique beneficiaries enrolled in an MCP as of the first of the month for the measurement period, by MCP</li> </ul>

Table 3.4 describes key specifications for this measure.

<sup>12</sup> To the extent possible, the population of licensed physicians identified from the Medical Board data will exclude physicians not actively practicing or accepting Medi-Cal beneficiaries.

**Table 3.4—Measure Specifications: Medi-Cal Managed Care Provider Penetration Rate**

Measure Element	Description
<b>Definition:</b>	The percentage of unique physicians licensed in the State of California as of September 1, 2017, that are contracted with one or more MCP, by MCP
<b>Data Source(s):</b>	DHCS data warehouse—provider data Medical Board provider data
<b>Stratification(s):</b>	Provider specialty, network status, geography
<b>Standard(s):</b>	Not applicable

### Provider-to-Beneficiary Ratio

the FTE is distributed proportionally based on MCP beneficiary populations. While both methods make broad assumptions regarding the availability of physicians for beneficiaries, the adjusted rates provide

<sup>13</sup> HSAG will apply both provider ratio adjustments to primary care and core specialty physicians. However, if PACES provider data contain complete and accurate FTE percentages for primary care physicians, HSAG will use the FTE percentage directly from the data. Additionally, where data are available, the FTE distribution will account for providers' contracts with non-Medi-Cal health plans and any contracts with other Medi-Cal MCPs.

more robust estimates than do raw counts of physicians. Table 3.5 describes key specifications for this measure.

**Table 3.5—Measure Specifications: Provider-to-Beneficiary Ratio**

Measure Element	Description
<b>Definition:</b>	The number of provider FTEs, as of the first of the month for the measurement period, relative to the number of MCMC beneficiaries by MCP
<b>Data Source(s):</b>	DHCS data warehouse—beneficiary, provider data
<b>Measurement Period:</b>	<ul style="list-style-type: none"> <li>◆ Point-in-time—September 1, 2017</li> <li>◆ Trend over time—monthly between January 2017 and September 2017</li> </ul>

Table 3.6 describes key

<sup>14</sup> Urbanicity (i.e., rural versus urban) will be based on DHCS classification of counties. See Appendix A.

**Table 3.6—Measure Specifications: Provider Counts by Geography**

Measure Element	Description
<b>Definition:</b>	<ul style="list-style-type: none"> <li>◆ The number of unique beneficiaries enrolled in an MCP as of the first of the month for the measurement period, by geography</li> <li>◆ The number of unique, active providers contracted with an MCP as of September 1, 2017, by provider specialty and by geography</li> </ul>
<b>Data Source(s):</b>	DHCS data warehouse—beneficiary, provider data
<b>Measurement Period:</b>	<ul style="list-style-type: none"> <li>◆ Point-in-time—September 1, 2017</li> <li>◆ Trend over time—monthly between January 2017 and September 2017</li> </ul>
	<ul style="list-style-type: none"> <li>◆ For beneficiaries—age (i.e., adult/child), geography (i.e., urbanicity designation)</li> </ul>

analysis will be limited to provider types where standards currently exist (i.e., primary care physicians<sup>15</sup> and hospitals).

<sup>15</sup> To the extent possible, drive time assumptions will be adjusted to account for varying traffic conditions and transportation options (e.g., public transportation).

<sup>16</sup> To the extent that data are available on whether or not PCPs are accepting new patients, time/distance results will be assessed for the entire provider network and for those PCPs accepting new patients.

**Table 3.7—Measure Specifications: Compliance with Time/Distance Standards**

Measure Element	Description
<b>Definition:</b>	The percentage of beneficiaries whose addresses fall within the time/distance standard established in the KKA or MCMC contracts for PCPs and hospitals, by MCP
<b>Data Source(s):</b>	DHCS data warehouse—beneficiary, provider data
<b>Measurement Period:</b>	Point-in-time—September 1, 2017
<b>Stratification(s):</b>	Network status
	For primary care physicians and hospitals—15 miles/30 minutes (KKA) or 10 miles/30 minutes (MCMC contract)

<b>Stratification(s):</b>	
<b>Standard(s):</b>	Not applicable

<sup>17</sup> To the extent that data are available on whether or not providers are accepting new patients, time/distance results will be assessed for the entire provider network and for those providers accepting new patients.

<sup>18</sup> Quest Analytics determines drive time based on the following parameters: 30 mph for urban, 45 mph for suburban, and 55 mph for rural. Estimates do not account for time of day, traffic, or traffic control devices (e.g., stop signs, stop lights); and may not mirror driver experience due to varying traffic conditions.

## Availability of Services

While the first two assessment dimensions assess provider network infrastructure, the following measures assess the extent to which the network infrastructure translates into practice. Measures of services available assess whether or not network services are relevant and effective in producing positive health outcomes. HSAG will use two types of measures to assess availability of services in the MCMC provider networks.

## Access-Related Complaints, Grievances, and Appeals

DHCS and DMHC monitor beneficiary experience through the collection and reporting of complaints, grievances, appeals, SFHs, and IMRs (all in the preceding list collectively referred to as grievances); this includes beneficiaries' access to health care services. HSAG will calculate grievance rates

<b>Standard(s):</b>	Not applicable

<sup>19</sup> Please note that HSAG will calculate five different but related access-related rates based on different data sources (i.e., beneficiary complaints, grievances, appeals, SFH requests, and IMRs).

## Service Utilization

HSAG will calculate utilization rates for several places of service to identify where beneficiaries are receiving services and to determine whether or not utilization patterns reflect appropriate management of health outcomes. Specifically, HSAG will calculate, per 1,000 member months by MCP, rates of emergency department (ED), urgent care, inpatient admissions, and outpatient visits. HSAG will also assess the utilization of alternative modalities (e.g., telemedicine). In the absence of standards, utilization rates are informational and are used comparatively to understand differences in how beneficiaries access services. Table 3.10 describes specifications for this measure.

**Table 3.10—Measure Specifications: Utilization Rates per 1,000 Member Months**

Measure Element	
	HEDIS 2017 Technical Specifications, Volume 2— <i>Ambulatory Care (AMB)</i> and <i>Inpatient Utilization—General Hospital/Acute Care (IPU)</i>
<b>Measurement Period:</b>	January 1, 2016, through December 31, 2016
<b>Stratification(s):</b>	Age, geography
<b>Standard(s):</b>	Not applicable

Additionally, using HEDIS IDSS and PLD files submitted by MCPs, HSAG will report a series of HEDIS measures designed to assess access to preventive, outpatient, and inpatient services. Table 3.11, Table 3.12, Table 3.13, and Table 3.14 describe the specifications for these measures.

**Table 3.11—Measure Specifications: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)**

Measure Element	Description
<b>Definition:</b>	The percentage of MCMC beneficiaries 3 through 6 years of age and enrolled in an MCP who had one or more well-child visits with a PCP during the measurement year.
<b>Data Source(s):</b>	DHCS—MCP IDSS and PLD files DHCS data warehouse—beneficiary data
<b>Technical Specifications:</b>	HEDIS 2017 Technical Specifications, Volume 2—W34
<b>Measurement Period:</b>	January 1, 2016–December 31, 2016

	Not applicable



**Table 3.13—Measure Specifications: Prenatal and Postpartum Care (PPC)**

Measure Element	Description
<b>Definition:</b>	<p>The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following:</p> <ul style="list-style-type: none"> <li>◆ <i>Timeliness of Prenatal Care.</i> The percentage of deliveries that received a prenatal visit as an MCMC beneficiary enrolled in an MCP in the first trimester, on the enrollment start date, or within 42 days of enrollment in an MCP.</li> <li>◆ <i>Postpartum Care.</i> The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</li> </ul>
<b>Data Source(s):</b>	<p>DHCS—MCP IDSS and PLD files DHCS data warehouse—beneficiary data</p>

	Not applicable

**Appointment Availability**

To evaluate appointment availability, HSAG will synthesize results from DHCS’s Post-Audit Timely Access Verification Study and Corrective Action Plan Verification Study to evaluate the average length of time it takes for an MCMC beneficiary to schedule an appointment. However, since the volume of data will vary by MCP, the results will be used for informational purposes only. Table 3.15 and

Table 3.16 describe two measures that examine the availability of appointments.

**Table 3.15—Measure Specifications: Average Number of Days to Appointment**

Measure Element	Description
<b>Definition:</b>	The average number of days to the soonest first, second, and third appointments by MCP

	10 business days (COHS)

## Analysis of Access to Care Monitoring

Although the Access assessment is limited to assessing network adequacy and timely access based on the standards defined in the KKA and MCMC contracts, HSAG will conduct a comparative desk review of California's existing network requirements, standards, and monitoring program relative to the Medicaid and CHIP revised final rule for Medicaid managed care (42 CFR 438). HSAG will conduct a comprehensive review of the KKA and MCMC contracts, the Medicaid and CHIP revised final rule for Medicaid managed care, and any documentation outlining DHCS's proposed approach to implementing CMS's final rule. HSAG will identify differences across the various documents and summarize if, and where, gaps exist. This qualitative approach will identify differences between the State's current network monitoring program and the requirements outlined in the CHIP managed care final rule (42 CFR 438).

While conducting the Access assessment, HSAG will document all limitations that potentially affect the results. These Access assessment limitations will be presented in the draft and final reports.

DRAFT

Following its assessment of the network adequacy of Medi-Cal’s managed care provider networks and subsequent synthesis of the findings, HSAG will prepare initial draft and final reports that highlight key findings, compliance with existing standards and access requirements, and any systemic recommendations. HSAG will produce both the initial draft and final reports in alignment with the STCs and the deliverables schedule included in Table 4.1.

### Access Assessment Reporting Layout

DRAFT

5. The **Conclusions and Recommendations** section will summarize the overall quality of access for Medi-Cal managed care beneficiaries, along with providing recommendations for DHCS to address systemic deficiencies and future monitoring requirements.

## Public Comment

After feedback from the AAAC has been received, processed, and incorporated into the initial draft report, and prior to HSAG producing the final report, DHCS will post the initial draft report on DHCS's website for a 30-day public comment period. This public comment period will take place no later than 10 months following CMS's approval of the Access assessment design.

Drawing on its extensive experience managing and analyzing public comments, HSAG will work collaboratively with DHCS to ensure that HSAG's process meets California requirements. HSAG will define and implement an appropriate platform for posting, receiving, and processing public comments. This process will include development of all communication materials including public notices, website updates, feedback instructions, response time frames, and public response templates. DHCS will review and approve all materials and documents to ensure that they meet State expectations and requirements.

DRAFT

Table 4.1.

**Table 4.1—Schedule of Access Assessment Events and Deliverables**

Event/Deliverable	Date
AAAC entrance meeting.	11/18/2016
HSAG submit Access assessment design outline to DHCS for review.	12/22/2016
<b>DHCS submit CA Access assessment design to CMS.</b>	<b>04/21/2017</b>
HSAG submit initial draft Access assessment report to DHCS for review.	02/27/2018
AAAC exit meeting.	March 2018
DHCS post Access assessment final report for public comment.	04/09/2018
<b>DHCS submit Access assessment report to CMS.</b>	<b>06/29/2018</b>

DRAFT

## Appendix A. Medi-Cal Managed Care Health Plan Reporting Unit and Urbanicity

MCP Name	MCP Abbreviation	MCP County/ Reporting Unit	Model	Urbanicity <sup>B</sup>
Alameda Alliance for Health	AAH	Alameda	LI	Medium
Anthem Blue Cross Partnership Plan	Anthem	Alameda	CP	Medium
		Contra Costa	CP	Medium
		Fresno	CP	Medium
		Kings	CP	Rural to Small
		Madera	CP	Rural to Small
		Sacramento	GMC	Medium
		San Francisco	CP	Medium
		Santa Clara	CP	Medium
		Tulare	LI	Medium
		Region 1 <sup>A</sup>	Regional	Medium
		Region 2 <sup>A</sup>	Regional	Medium
		San Benito	San Benito	Rural to Small
California Health & Wellness Plan	CHW	Imperial	Imperial	Rural to Small
		Region 1 <sup>A</sup>	Regional	Medium
		Region 2 <sup>A</sup>	Regional	Medium
CalOptima	CalOptima	Orange	COHS	Medium
CalViva Health	CalViva	Fresno	LI	Medium
		Kings	LI	Rural to Small
		Madera	LI	Rural to Small
Care1st Partner Plan	Care1st	San Diego	GMC	Medium
CenCal Health	CenCal	Santa Barbara	COHS	Medium
		San Luis Obispo	COHS	Medium
Central California Alliance for Health	CCAH	Monterey/Santa Cruz	COHS	Medium
		Merced	COHS	Rural to Small
Community Health Group Partnership Plan	CHG	San Diego	GMC	Medium
Contra Costa Health Plan	CCHP	Contra Costa	LI	Medium
Gold Coast Health Plan	Gold Coast	Ventura	COHS	Medium
Health Net Community Solutions, Inc.	Health Net	Kern	CP	Medium
		Los Angeles	CP	Large
		Sacramento	GMC	Medium
		San Diego	GMC	Medium
		San Joaquin	CP	Medium
		Stanislaus	CP	Medium
		Tulare	CP	Medium
Health Plan of San Joaquin	HPSJ	San Joaquin	LI	Medium
		Stanislaus	LI	Medium
Health Plan of San Mateo	HPSM	San Mateo	COHS	Medium

